

March 26, 2012

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On February 22, 2012, representatives of five projects in the FCC's Rural Health Care Pilot Program (RHCPP) spoke via telephone with Linda Oliver, Christianna Barnhart, Chin Yoo, and Samantha Flanzer of the Wireline Competition Bureau. These representatives were Bill Sorrels, Executive Director, Alaska eHealth Network; Dr. Dale Alverson, Project Coordinator, Southwest Telehealth Access Grid; Rick Burgin, Tennessee Telehealth Network; Eugene Sullivan, Virginia Acute Stroke Telehealth Project; and Hank Fanberg, Texas Health Information Network Collaborative. The purpose of the call was to discuss the telecommunications needs of rural health care providers (HCPs) in response to the Commission's July 15, 2010, Notice of Proposed Rulemaking in the above-referenced docket. The pilot project participants discussed the current or expected benefits that broadband had brought to their projects, and identified challenges faced during the application and implementation process. They also suggested potential areas for improvement.

Telemedicine applications: Mr. Sullivan highlighted the advances the Virginia Acute Stroke Telehealth (VAST) Project recently achieved for its network on the Eastern Shore of Virginia. Prior to the pilot project, the Eastern Shore was unable to attract broadband services to the area. There was little economic incentive for service providers to bring broadband there, knowing that they might serve just one institution. However, with the pilot program, service providers will now offer broadband services to Eastern Shore Rural Health System (ESRHS), which consists of five clinics and two dental locations. The commitment from ESRHS to connect these seven anchor institutions resulted in at least one (and potentially two) vendor responses to the VAST RFP. Additionally the ESRHS is signing an agreement with the University of Virginia to provide telemedicine services to citizens on the Eastern Shore. Mr. Sullivan also noted that, in general, interest in the VAST Project accelerated once the initial sites showed that the proposed uses were viable.

Participants also noted that the inclusion of urban sites in the pilot program was critical to providing specialty care, because of the shortage of specialists in rural areas. Because their pilot projects are still being implemented, some of the participants noted that the telehealth benefits from the FCC pilot program were not yet realized. The participants also noted that other obstacles to telemedicine remain (such as reimbursement and licensing issues).

Dr. Alverson noted that physician involvement is key to broad telemedicine adoption, and that telemedicine must be "needs driven." Each state is different in its adoption rates, but New Mexico has over 30 active telehealth programs. He also said that Health Information Exchange (HIE) is quickly beginning to overlap with telemedicine, because capabilities that allow for transmission of large health information files, such as medical images, can avoid unnecessary duplication of tests, as well as having other benefits. He added that the FCC's rural health care program is critical to improving health care throughout the country, and that broadband is a foundational component. He stated that many attributes of the program were well thought out.

Administrative barriers: A number of participants emphasized the difficulties faced in raising sufficient administrative funds to engage stakeholders and pursue the complex application and proposal process. One participant had already invested \$500,000 in administrative expenses, because so many stakeholders were involved, and another stated that it currently had a seven figure budget for administrative expenses. They suggested that USAC fund administrative expenses associated with the application process and project management, noting that grant programs typically do fund such expenses. To mitigate high costs of participating in the program, participants suggested allowing in-kind contributions to count towards their 15 percent match requirements.

Additionally, participants noted their frustration about perceived ambiguities regarding site eligibility, particularly with regard to data centers and administrative hubs, and regarding eligibility of expenses, such as issues about funding for a bridge and for end-points versus network equipment. One participant also was concerned by the delay caused by having to wait 30 days after issuance of the RFP, and others were concerned about other sources of administrative delay.

Long term sustainability plan: While recognizing the importance of a long term sustainability plan, participants nonetheless expressed concern about sustainability plans longer than five years given rapid and unpredictable changes in healthcare and broadband technology and needs. One participant said it was difficult to develop a sustainability plan because that requirement was added later in the application process.

Vendor education: Participants noted that the pilot program represented a significant improvement in billing procedures over the Primary Rural Health Care program, as cash-strapped providers are no longer required to pay 100 percent of cost and then seek reimbursement. However, one participant stated he would like to see additional vendor education regarding the pilot project's billing processes, as vendors are unaccustomed to receiving bills on a piecemeal basis. One project had difficulty getting its vendors to complete the necessary forms.

Role of coaches: Some participants valued the support USAC coaches provided. Others found USAC staff more helpful than the coaches in navigating the application process, and would like to see resources devoted to coaches directed elsewhere.

"Network of networks" challenges: Several of the participants described their ultimate goal as achieving a "network of networks" linking pre-existing networks of health care providers together, sometimes with planned state-wide coverage. In some ways, the large hoped-for scale and scope of some of the projects as conceived made it more difficult to move through the organizational and application process. At least two of the participants stated that these efforts were complicated by the FCC's letter of agency (LOA) requirements. Currently, any organization potentially part of a participant's network of networks must sign an LOA, even if the organization is not part of the project (e.g., public health departments). For many participants this created a "barrier they could not overcome" due to the sheer volume of LOAs required and reluctance on the part of some organizations within the "network of networks" to sign the LOA.

Construction versus leased services. Dr. Alverson stated that in his experience, most stakeholders prefer not to own the physical facilities comprising their network. Instead, the stakeholders would rather defer to service providers that have experience and expertise in these matters to complete any necessary build out. In cases where construction is necessary, the health care provider may issue two RFPs – one for construction and one for an experienced entity to manage the network on behalf of the health care provider.

Mr. Fanberg said that program requirements on excess capacity created challenges as to the degree participants could coordinate with broadband objectives in Texas, and that the network was underutilized as a result. Other projects stated that the rules for “self-provisioning” (*i.e.* health care provider-owned networks) were unclear.

Coordination with ARRA broadband programs: Participants emphasized the need for greater FCC coordination with the ARRA Broadband Initiative Program (BIP) and the Broadband Technology Opportunities Program (BTOP). Two participants stated the format and structure of obtaining BIP and BTOP was “almost in opposition to the FCC project” as they often found themselves competing with both programs to engage providers in their network.

Differences between “primary” and “pilot” programs. The participants also discussed differences between the FCC’s “primary” rural health care program, which funds the differential between urban and rural rates, and the pilot program. They generally liked having a set discount rate, rather than having to calculate the urban/rural differential. Mr. Sorrels observed that one of the challenges the pilot program faces in Alaska is that it does not compete very well with the primary program. Anchorage is the only urban center in the State, and in most instances health care providers rely on satellite, not fiber, for their broadband needs. However, other participants were not in favor of the urban/rural differential rates, finding them “unequal.” For example, Mr. Sullivan from the Virginia Acute Stroke Telehealth Project (VAST) stated that while the sites associated with the University of Virginia may have knowledge of a favorable urban rate, a clinic that does not work with University of Virginia may not have access to the same administrative resources, and as a result may not become aware of that same urban rate. He stated that a flat discount rate, if a large enough percentage, was a preferable approach. He noted that the discount level in the primary program for Virginia sites is about 60-71%.

HHS engagement: Participants stated they would appreciate greater HHS collaboration and engagement, particularly with regard to gaining a better understanding of how best to align their broadband goals with “meaningful use” guidelines for adoption of electronic health records and regarding achievement of a robust health information exchange network. To that end, participants requested that the healthcare-related questions on the quarterly reports be updated.

Respectfully submitted,

/s/
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Wireline Competition Bureau